CONTRACT DATA SHEET

PSC Type (check one): _____New _X_Renewal _____Addendum

Contractor Information

1. Legal Name of Contractor: **University of Louisville Department of Radiology**
2. Address: **530 South Jackson Street, Suite C07**
3. City/ State & Zip: **Louisville, KY 40202**
4. Contact Person Name & Telephone Number: **Donna J. Richardson (502) 852-1753**
5. Revenue Commission Taxpayer ID#:
6. If registration is not required please e
7. Is account in good standing: **Yes**
8. Federal Tax ID # (SSN if sole proprietor):

Department Information

9. Requesting Department: **Public Health and Wellness**
10. Contact Person Name & Telephone: **MaDonna White, 574 – 5219; Jennifer Clark 574 - 6531**

Contract Information

11. Not to exceed amount: **$18,000**
12. Are expenses reimbursed? **No**
13. If yes list allowable expenses and maximum amount reimbursable:
14. Beginning and ending date of the contract: **7/1/09 – 6/30/10**
15. Coding: **1101- 605 – 4142 – 411525 - 521362**
16. Scope & Purpose of the contract: **To provide radiological interpretation services in the Louisville Metro Department of Public Health and Wellness Tuberculosis (TB) Clinic, including chest X-rays at a rate of $16.67 a patient, black lung readings at $50 a patient and $25 for any STAT service.**

Authorizations

WHOS County Attorney Review - Approved as to Form:

Department Director: _____ Date: 3/17/09

Signature certifies:

N/A *Funds are available* $14,000 LIMIT @ 3/12/09

JW *Contractor is registered and in good standing with the Revenue Commission*

JW *Human Relations Commission registration requirements have been met*

CJK Risk Management Division of Finance - Certifies Insurance requirements satisfied: 7-10-09

WRITTEN FINDINGS

EXPLAINING NECESSITY FOR USING NONCOMPETITIVE NEGOTIATION FOR PSC

This document constitutes written request and findings, as required by KRS 45A.380 stating the need to purchase through noncompetitive negotiation for PSC Contract # _____. By the signatures listed below, the Requesting Department has determined, and the Chief Financial Officer concurs, that competition is not feasible because:

_____ A. An emergency exists which will cause public harm as a result of the delay in competitive procedures. **** Mayors Approval required for emergency purchases exceeding $10,000.**

_____ B. There is a single source within a reasonable geographic area of the supply or service to be procured or leased (attach sole source determination from the Purchasing Department).

____X____ C. The contract is for the services typically provided by a licensed professional, such as an attorney, architect, engineer, physician, certified public accountant, registered nurse, or educational specialist; a technician such as a plumber, electrician, carpenter, or mechanic; an artist such as a sculptor, aesthetic painter, or musician; or a non-licensed professional such as a consultant, public relations consultant, advertising consultant, developer, employment department, construction manager, investment advisor, or marketing expert and the like.

_____ D. The contract is for the purchase of perishable items purchased on a weekly basis, such as fresh fruits, vegetables, fish, or meat.

_____ E. The contract is for replacement parts where the need cannot reasonably be anticipated and stockpiling is not feasible.

_____ F. The contract is for proprietary items for resale.

_____ G. The contract or purchase is for expenditures made on authorized trips outside the boundaries of the city.

_____ H. The contract is for the purchase of supplies which are sold at public auction or by receiving sealed bids.

_____ I. The contract is for group life insurance, group health and accident insurance, group professional liability insurance, worker's compensation insurance, or unemployment liability insurance.

_____ J. The contract is for a sale of supplies at reduced prices that will afford a purchase at savings to the Metro Government.

_____ K. The contract was solicited by competitive sealed bidding and no bids were received from a responsive and responsible bidder.

_____ L. Where, after competitive sealed bidding, it is determined in writing that there is only one (1) responsive and responsible bidder.

_____ 3/17/09
Requesting Department Director Date

_____
**Mayor Date

*****Signature is required only for Written Finding A***

AGREEMENT

THIS PROFESSIONAL SERVICE CONTRACT, made and entered into by and between the **LOUISVILLE/JEFFERSON COUNTY METRO GOVERNMENT,** by and through its **LOUISVILLE METRO DEPARTMENT OF PUBLIC HEALTH AND WELLNESS** herein referred to as **"METRO GOVERNMENT" or "LMPHW"**, and **UNIVERSITY OF LOUISVILLE,** acting by and through its **DEPARTMENT OF RADIOLOGY** with offices located at 530 South Jackson Street , Suite CO7, Louisville, Kentucky 40202 herein referred to as **"CONSULTANT",**

W I T N E S S T H:

WHEREAS, the Metro Government requires radiological interpretation services for LMPHW's Tuberculosis Clinic; and

WHEREAS, pursuant to K.R.S. 45A.380 METRO has determined that competition is not feasible and that this Agreement is for the services of a professional

NOW, THEREFORE, it is agreed by and between the parties hereto as follows:

I. SCOPE OF PROFESSIONAL SERVICES

A. Consultant shall, at the request of the Metro Government, provide services under the terms of this professional Agreement. The Consultant's work product may be reviewed from time to time by the Metro Government for purposes of determining that the services provided are within the scope of this Agreement.

B. If from time to time Consultant needs to utilize the records or personnel of the Metro Government relative to performing the services required of this Agreement, then Consultant shall notify the proper agent of the Metro Government of this need and arrangements may be made for that contingency. However, at no time shall the Metro Government make available its resources without the full consent and understanding of both parties.

C. Consultant, while performing the services rendered pursuant to this Agreement, may incidental thereto utilize agents or employees of such Consultant. However, such use must be documented in the monthly invoice submitted for those services rendered.

D. The services of Consultant shall include but not be limited to the following:

1. Radiological interpretation services.

II. FEES AND COMPENSATION

A. The Metro Government shall pay Consultant for appropriately documented services rendered in accordance with Paragraph One (1) of this Agreement. The Metro Government shall reimburse Consultant at the rate of **SIXTEEN DOLLARS AND SIXTY SEVEN CENTS ($16.67)** per chest x-ray, based on a volume of 84 readings of those x-rays per month and **FIFTY DOLLARS ($50.00)** per B-read (Black Lung) x-ray interpretation. When LMPHW requests immediate interpretation services, however, the rate shall be an additional **TWENTY-FIVE DOLLARS ($25.00)** per chest x-ray or B-read x-ray.

The total compensation paid pursuit to this Agreement shall not exceed **EIGHTEEN THOUSAND DOLLARS ($18,000.00).**

LMPHW shall not send any x-ray to Consultant for interpretation once the not to exceed amount of this Agreement is reached.

B. Unless otherwise agreed to in writing by the Metro Government, services shall be rendered and payment therefore shall be made at monthly intervals throughout the duration of this Agreement. Payment shall only be made pursuant to a detailed invoice presented monthly, which invoice shall indicate the particular nature of the services rendered.

C. The Metro Government shall not reimburse out of pocket expenses under this Agreement.

D. Consultant, to the extent that it provides the same or related services to other parties agrees to pro-rate its billings to the Metro Government which are of benefit to the other parties and to provide documentation to all parties to verify the pro-ration of such billings. In no event will the Metro Government pay bills which are considered to be double billing (i.e. billing two different parties for the same work).

E. Consultant agrees that all outstanding invoices at the end of the fiscal year (June 30) must reach the Metro Government no later than July 15 of the following fiscal year. Consultant agrees that original invoices that are not in Metro Government possession by this time will not be paid and Consultant agrees to waive its right to compensation for services billed under such invoices.

F. In order to transmit images to the consultant and be returned to LMPHW a courier service will be initiated by LMPHW. LMPHW shall be responsible for all costs associated with the courier service.

III. DURATION

A. This Agreement shall begin July 1, 2009 and shall continue through and including June 30, 2010.

B. This Agreement may be terminated by submitting thirty (30) days' written notice to the non-terminating party of such intent to terminate. This Agreement may also be terminated by any party, without notice to the non-terminating party, because of fraud, misappropriation, embezzlement or malfeasance or a party's failure to perform the duties required under this Agreement. A waiver by either party of a breach of this Agreement

Agreement shall not operate or be construed as a waiver of any subsequent breach.

C. In the event of termination, payment for services complete up to and including date of termination shall be based upon work completed at the rates identified in this Agreement. In the event that, during the term of this Agreement, the Metro Council fails to appropriate funds for the payment of the Metro Government's obligations under this Agreement, the Metro Government's rights and obligations herein shall terminate on the last day for which an appropriation has been made. The Metro Government shall deliver notice to Consultant of any such non-appropriation not later than 30 days after the Metro Government has knowledge that the appropriation has not been made.

IV. EMPLOYER/EMPLOYEE RELATIONSHIP

It is expressly understood that no employer/employee relationship is created by this Agreement nor does it cause Consultant to be an officer or official of the Metro Government. By executing this Agreement, the parties hereto certify that its performance will not constitute or establish a violation of any statutory or common law principle pertaining to conflict of interest, nor will it cause unlawful benefit or gain to be derived by either party.

V. RECORDS-AUDIT

Consultant shall maintain during the course of the work, and retain not less than five years from the date of final payment on the contract, complete and accurate records of all of Consultant's costs which are chargeable to the Metro Government under this Agreement; and the Metro Government shall have the right, at any reasonable time, to inspect and audit those records by authorized representatives of its own or of any public accounting firm selected by it. The records to be thus maintained and retained by

and retained by Consultant shall include (without limitation): (a) payroll records accounting for total time distribution of Consultant's employees working full or part time on the work (to permit tracing to payrolls and related tax returns), as well as canceled payroll checks, or signed receipts for payroll payments in cash; (b) invoices for purchases receiving and issuing documents, and all the other unit inventory records for Consultant's stores stock or capital items; and (c) paid invoices and canceled checks for materials purchased and for subcontractors' and any other third parties' charges.

VI. HOLD HARMLESS AND INDEMNIFICATION CLAUSE

Consultant and the University of Louisville (U of L), as agencies of the Commonwealth of Kentucky, although vested with sovereign immunity, are subject to the Board of Claims Act, KRS 44.070-44.160. Claims against Consultant and U of L relating to personal injury or property damage may be filed and decided under the provisions of the Act. To the extent permitted by that Act and other applicable law, the Consultant, as agent for the University of Louisville for receiving grants and research agreements from external funding sources, shall defend, indemnify and hold harmless the Metro Government from and against any and all claims which may result from any error or omission arising out of Consultant's and U of L's performance under this Agreement.

VII. INSURANCE REQUIREMENTS

Insurance coverage shall be required of Consultant in accordance with Schedule A attached hereto.

VIII. REPORTING OF INCOME

The compensation payable under this Agreement may be subject to federal, state and local taxation. Regulations of the Internal Revenue Service require the Metro Government to report all amounts in excess of $600.00 paid to non-corporate contractors. Consultant agrees to furnish the Metro Government with its taxpayer identification number (TIN) prior to the effective date of this Agreement. Consultant further agrees to provide such other information to the Metro Government as may be required by the IRS or the State Department of Revenue.

IX. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of Kentucky. In the event of any proceedings regarding this Agreement, the Parties agree that the venue shall be the state courts of Kentucky or the U.S. District Court for the Western District of Kentucky, Louisville Division. All parties expressly consent to personal jurisdiction and venue in such Court for the limited and sole purpose of proceedings relating to this Agreement or any rights or obligations arising thereunder. Service of process may be accomplished by following the procedures prescribed by law.

X. AUTHORITY

The Consultant, by execution of this Agreement, does hereby warrant and represent that it is qualified to do business in the State of Kentucky, has full right, power and authority to enter into this Agreement.

XI. CONFLICTS OF INTEREST

Pursuant to KRS 45A.455:

(1) It shall be a breach of ethical standards for any employee with procurement authority to participate directly in any proceeding or application; request for ruling or other determination; claim or controversy; or other particular matter pertaining to any contract, or subcontract, and any solicitation or proposal therefor, in which to his knowledge:

(a) He, or any member of his immediate family has a financial interest therein; or

(b) A business or organization in which he or any member of his immediate family has a financial interest as an officer, director, trustee, partner, or employee, is a party; or

(c) Any other person, business, or organization with whom he or any member of his immediate family is negotiating or has an arrangement concerning prospective employment is a party. Direct or indirect participation shall include but not be limited to involvement through decision, approval, disapproval, recommendation, preparation of any part of a purchase request, influencing the content of any specification or purchase standard, rendering of advice, investigation, auditing, or in any other advisory capacity.

(2) It shall be a breach of ethical standards for any person to offer, give, or agree to give any employee or former employee, or for any employee or former employee to solicit, demand, accept, or agree to accept from another person, a gratuity or an offer of employment, in connection with any decision, approval, disapproval, recommendation, preparation of any part of a purchase request, influencing the content of any specification or purchase standard, rendering of advice, investigation, auditing, or in any other advisory capacity in any proceeding or application, request for ruling or other

other determination, claim or controversy, or other particular matter, pertaining to any contract or subcontract and any solicitation or proposal therefor.

(3) It is a breach of ethical standards for any payment, gratuity, or offer of employment to be made by or on behalf of a subcontractor under a contract to the prime contractor or higher tier subcontractor or any person associated therewith, as an inducement for the award of a subcontract or order.

(4) The prohibition against conflicts of interest and gratuities and kickbacks shall be conspicuously set forth in every local public agency written contract and solicitation therefor.

(5) It shall be a breach of ethical standards for any public employee or former employee knowingly to use confidential information for his actual or anticipated personal gain, or the actual or anticipated personal gain of any other person.

XII. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement and understanding of the parties with respect to the subject matter set forth herein and this Agreement supersedes any and all prior and contemporaneous oral or written agreements or understandings between the parties relative thereto. No representation, promise, inducement, or statement of intention has been made by the parties that is not embodied in this Agreement. This Agreement cannot be amended, modified, or supplemented in any respect except by a subsequent written agreement duly executed by all of the parties hereto.

XIII. OCCUPATIONAL HEALTH AND SAFETY

Consultant agrees to comply with all statutes, rules, and regulations governing safe and healthful working conditions, including the Occupational Health and Safety Act

of 1970, *29 U.S.C. 650 et. seq.*, as amended, and KRS Chapter 338. Consultant also agrees to notify the Metro Government in writing immediately upon detection of any unsafe and/or unhealthful working conditions detected at any Metro-owned property where Consultant performs work under this Agreement. Consultant agrees to indemnify, defend and hold the Metro Government harmless from all penalties, fines or other expenses arising out of the alleged violation of said laws.

XIV. SUCCESSORS

This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, successors and assigns.

XV. SEVERABILITY

If any court of competent jurisdiction holds any provision of this Agreement unenforceable, such provision shall be modified to the extent required to make it enforceable, consistent with the spirit and intent of this Agreement. If such a provision cannot be so modified, the provision shall be deemed separable from the remaining provisions of this Agreement and shall not affect any other provision hereunder.

XVI. COUNTERPARTS

This Agreement may be executed in counterparts, in which case each executed counterpart shall be deemed an original and all executed counterparts shall constitute one and the same instrument.

XVII. CALCULATION OF TIME Unless otherwise indicated, when the performance or doing of any act, duty, matter, or payment is required hereunder and a period of time or duration for the fulfillment of doing thereof is prescribed and is fixed herein, the time shall be computed so as to exclude the first and include the last day of the prescribed or fixed period of time. For example, if on January 1, Consultant is

directed to take action within ten (10) calendar days, the action must be completed no later than midnight, January 11.

XVIII. CAPTIONS The captions and headings of this Agreement are for convenience and reference purposes only and shall not affect in any way the meaning and interpretation of any provisions of this Agreement.

XIX. MISCELLANEOUS Consultant agrees that, in the event it receives from the Metro Government any protected health information, it will not disclose any of that information to any third party and, in that regard, Consultant agrees to comply with the rules and regulations of the Health Insurance Portability and Accountability Act ("HIPAA"), codified in 42 U.S.C. § 1320d and 45 C.F.R. 160-164. Consultant shall hold in strictest confidence all documentation, information, and observations gathered in the performance of this Agreement, and Consultant agrees to sign the Health Department Business Associate Agreement. Consultant further agrees to require any of its subcontractors to both abide by the aforementioned HIPAA prohibitions against the unauthorized disclosure of confidential and protected health information and to sign the Metro Government's Business Associate Agreement.

The Metro Government and Consultant agree to comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et. seq.*) and all implementing regulations and executive orders, and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701) and the Kentucky Equal Employment Act of 1978 (K.R.S. § 45.550 to 45.640) and the Americans with Disabilities Act (42 U.S.C. § 12101 *et. seq.*). No person shall be excluded from participation in, be denied the benefits of, or be subject to discrimination in relation to activities carried out under this Agreement on the basis of race, color, age, religion, sex, disability or national origin. This includes provision of language assistance

services to individuals of limited English proficiency seeking and/or eligible for services under this Agreement.

Consultant nor any of its employees or personnel shall speak on behalf of or as a representative of the Metro Government or the Department of Public Health and Wellness without the express authorization of the Director of that Department or his designee.

The Consultant shall reveal any final determination of a violation by the Consultant or subcontractor within the previous five (5) year period pursuant to KRS Chapters 136, 139, 141, 337, 338, 341 and 342 that apply to the Consultant or subcontractor. The Consultant shall be in continuous compliance with the provisions of KRS Chapters 136, 139, 141, 337, 338, 341 and 342 that apply to the Consultant or subcontractor for the duration of the contract.

SCHEDULE A

INSURANCE REQUIREMENTS FOR MEDICAL PROFESSIONAL

I. INSURANCE REQUIREMENTS

Prior to commencing work Consultant shall obtain at its own cost and expense the following types of insurance through insurance companies licensed in the State of Kentucky. Insurance written by non-admitted carriers will also be considered acceptable, in accordance with Kentucky Insurance Law (KRS 304.10-040). Workers' Compensation written through qualified group self-insurance programs in accordance with Kentucky Revised Statutes (KRS 342.350) will also be acceptable. **The Consultant shall not commence work under this Contract until all insurance required under the Contract Document has been obtained and until copies of policies or certificates thereof are submitted to and approved by the Louisville/Jefferson County Metro Government's Risk Management Division.** The *Consultant shall not allow any subcontractor to commence work until the insurance required of such subcontractor has been obtained and copies of Certificates of Insurance retained by Consultant evidencing proof of coverages.*

Without limiting Consultant's indemnification requirements, it is agreed that Consultant shall maintain in force at all times during the performance of this agreement the following policy or policies of insurance covering its operations, and *require subcontractors, if subcontracting is authorized, to procure and maintain these same policies* until final acceptance of the work by the Louisville/Jefferson County Metro Government. The Louisville/Jefferson County Metro Government may require Consultant to supply proof of subcontractor's insurance via Certificates of Insurance, or at Louisville/Jefferson County Metro Government's option, actual copies of policies.

1. The Consultant shall purchase and maintain at their own expense a **PROFESSIONAL LIABILITY (Errors and Omissions Liability) insurance** policy, **which includes a minimum limit of liability of $1,000,000 for each Wrongful Act,** covering the Consultant and all physicians, nurses etc assigned or authorized by Consultant under this agreement. In the event that the Consultant 's policy is written on a "Claims Made" Form, the Consultant shall, after work has been completed, furnish evidence that the liability coverage has been maintained for at least one year after completion of work, either by submitting renewal policies with a Retroactive Date of not later than the date work commenced under this contract, or by evidence that the Consultant has purchased an Extended Reporting Period Endorsement that will apply to any and all claims arising from work performed under this contract.

2. WORKERS' COMPENSATION insuring the employers' obligations under Kentucky Revised Statutes Chapter 342 at Statutory Limits, and EMPLOYERS' LIABILITY - **$100,000** Each Accident/**$500,000** Disease - Policy Limit/**$100,000** Disease - Each Employee.

II. MISCELLANEOUS

A. The Consultant shall procure and maintain insurance policies as described herein and for which the Louisville/Jefferson County Metro Government shall be furnished Certificates of Insurance upon the execution of the Contract. The Certificates shall include provisions stating that the policies may not be cancelled without the Louisville/Jefferson County Metro Government having been provided at least (30) thirty days written notice. The Certificates shall identify the Contract to which they apply and shall include the name and address of the person executing the Certificate of Insurance as well as the person's signature. If policies expire before the completion of the Contract, renewal Certificates of Insurance shall be furnished to the Louisville/Jefferson County Metro Government's Risk Management Division at least 30 days prior to the expiration of any policy(s). Certificates of Insurance as required above shall be furnished, as called for:

Louisville/Jefferson County Metro Government
Finance Department, Risk Management Division
611 West Jefferson Street
Louisville, KY 40202

B. The Consultant agrees that it will not materially alter any of the insurance policies currently in force and relied on under this agreement. Further, the Consultant will not reduce any coverage amount below the limits required in this agreement

C. Approval of the insurance by the Louisville/Jefferson County Metro Government shall not in any way relieve or decrease the liability of the Consultant hereunder. It is expressly understood that the Louisville/Jefferson County Metro Government does not in any way represent that the specified Limits of Liability or coverage or policy forms are sufficient or adequate to protect the interest or liabilities of the Consultant.

WITNESS the agreement of the parties hereto by their signatures affixed hereon.

APPROVED AS TO FORM AND LEGALITY:

MICHAEL J. O'CONNELL
JEFFERSON COUNTY ATTORNEY

Date: 6/3/09

LOUISVILLE/JEFFERSON COUNTY METRO GOVERNMENT

DR. ADEWALE TROUTMAN, M.D.,
DIRECTOR, DEPARTMENT FOR PUBLIC HEALTH AND WELLNESS

Date: 6/16/09

UNIVERSITY OF LOUISVILLE APPROVED AS TO FORM:

Glenn Bossmeyer 6/9/09
Date

RECOMMENDED:

Gregory C. Postel, MD 6/9/09
Date
Professor and Chairman, Dept of Radiology

EC Halpe 06.10.09
Edward C. Halperin, MD, MA Date
Dean, School of Medicine

APPROVED:

6-9-09
Larry Cook, MD Date
Executive Vice President for Health Affair

Taxpayer Identification No.
(TIN):__ _____

Louisvi
Revenue Commission Account
No.:___ _____

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Madgy A. Abaskaron, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-01
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-01 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Authorized Signature

12/16/2008

Cancel 6-30-09

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Irwin Randell Cohen, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-06
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-06 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Donald Lee Evans, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-07
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-07 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Richard L. Goldwin, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-08
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-08 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Peter C. Hentzen, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-09
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-09 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lau

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Tsung-Yao Huang, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-10
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-10 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Nettie G. King, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-11
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-11 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Brenda L. Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Elvedin Kulenovic, M.D.
Specialty: Radiology/Musculoskeletal
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-12
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-12 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Brenda L. Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Gregory C. Postel, M.D.
Specialty: Radiology/Neuroradiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-15
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-15 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: James Croft Reed, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-16
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-16 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Brenda L. Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Albert Seow, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 01/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-17
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-17 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Harry Michael Rice, M.D.
Specialty: Radiology/Nuclear Medicine
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 02/01/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-19
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-19 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L. Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Terry T. Brown, M.D.
Specialty: Diagnostic Radiology/Musculoskeletal
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 07/01/2005
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-20
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-20 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Lane M. Roland, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 07/12/2004
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-21
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-21 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L Lau
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Darren Lee Cain, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 04/01/2006
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-24
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-24 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lee

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Mahmoud Samman, M.D.
Specialty: Radiology/Interventional
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 07/01/2006
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-26
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-26 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L Love

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Garth M. Beache, M.D.
Specialty: Diagnostic Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 09/05/2006
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-29
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-29 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L. Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Richard K. Downs, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 05/01/2007
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-31
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-31 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Brenda L. Lee

Authorized Signature

12/16/2008

Clearing

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Alina Uzelac, D.O.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 06/01/2007
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-32
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-32 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Sarah G. Mizuguchi, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 09/01/2007
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-33
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-33 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Belinda L. Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Jens O. Heidenreich, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 11/01/2007
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-34
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-34 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Kayiguvwe O. Kragha, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 12/01/2007
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-35
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-35 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance

Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: A. Cahid Civelek, M.D.
Specialty: Nuclear Medicine
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 02/01/2008
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-36
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-36 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Brenda L. Lane

Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Sheereen Azimpoor, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 04/01/2008
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-37
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-37 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Brenda L. Lee
Authorized Signature

12/16/2008

KENTUCKIANA MEDICAL RECIPROCAL RISK RETENTION GROUP

550 South Jackson
Ambulatory Care Building, Suite A1J03
Louisville, KY 40202

Telephone: (502) 562 - 8004
Facsimile: (502) 562 - 5766

Certificate of Insurance
Physician Professional Liability Coverage

Coverage applies on behalf of those individuals and entities who are named on the Schedule of Insureds submitted to the Company by the Named Insured:

Insured: Thomas P. Eberle, M.D.
Specialty: Radiology
Group Name: University Radiological Associates, PSC
Address: 530 South Jackson Street C07
Louisville, KY 40202

Coverage Term: 12:01 AM 01/01/2009 to 12:01 AM 01/01/2010 Eastern Standard Time
Retroactive Date: 09/01/2008
Coverage Form: Modified Claims Made
Coverage Type: Broad Form
Policy Number: L3003-09-38
Limits of Liability: $1,000,000 Each Claim / $3,000,000 Annual Aggregate

Coverage Notes: The Limits of Liability evidenced above apply separately to the PSC or Group. Further, PSC or Group limits are shared with all allied health professionals and other non-physician employees named on the Schedule of Insured Allied Health Professionals, but only while acting within the scope of their employment duties.

This Certificate of Insurance has been issued based upon the representations and warranties made in your application.

The insurance provided is subject to all of the terms and conditions of the above referenced policy. Coverage terminates at the earlier of:

A. The date upon which you elect to cancel coverage; or
B. The date upon which you no longer meet eligibility requirements; or
C. The failure to make payment of premiums as invoiced

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by policy number L3003-09-38 issued by the Kentuckiana Medical Reciprocal Risk Retention Group.

Linda L. Lee
Authorized Signature

ACORD CERTIFICATE OF LIABILITY INSURANCE

OP ID MB UNIVE-5

DATE (MM/DD/YYYY) 06/23/09

PRODUCER

Commonwealth Risk SolutionsLTD
PO Box 24233
Louisville KY 40224
Phone: 502-753-1231 Fax: 502-736-7001

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

University of Louisville
Contract Admin & Risk Mgt
1900 Arthur ST, Ste 100
Louisville KY 40208

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: The PMA Insurance Group	12262
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurence)	$
		CLAIMS MADE OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
						GENERAL AGGREGATE	$
		GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG	$
		POLICY PRO-JECT LOC					
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		HIRED AUTOS				BODILY INJURY (Per accident)	$
		NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR CLAIMS MADE				AGGREGATE	$
							$
		DEDUCTIBLE					$
		RETENTION $					$
A		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	200700-91-25-80-8	07/01/09	07/01/10	X WC STATU-TORY LIMITS OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT	$ 500,000
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$ 500,000
						E.L. DISEASE - POLICY LIMIT	$ 500,000
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

RE: Contract services performed by Dr. Schickler, 07/01/08-07/01/09.

CERTIFICATE HOLDER

LOUI-10

Louisville Jefferson Co Metro
Finance Dept
Risk Management Division
611 W. Jefferson St
Louisville KY 40202-3309

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

John B. Nelson III